PERSONNEL CABINET
GROUP LIFE INSURANCE ADMINISTRATION

EMPLOYEE CHANGE REQUEST

SOCIAL SECURITY NUMBER: _____

EMPLOYEE NAME: _____

STREET ADDRESS: _____

CITY: _____

STATE: _____

ZIP CODE: _____

DATE OF BIRTH: _____

GENDER: _____

COUNTY: _____

LOCATION: _____
(location number) (location name)

EMPLOYMENT HIRE DATE: _____
(Enrollment must be sent to Personnel for new hires or plan changes)

EMPLOYMENT TERMINATION DATE: _____

Please return completed form to: **Personnel Cabinet**
Group Life Insurance Administration
200 Fair Oaks Lane, Room 503
Frankfort, Kentucky 40601